Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Notice of Independent Review Decision

Date notice sent to all parties: 09/07/12

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Right sided L4-L5 transforaminal epidural steroid injection (ESI)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Orthopedic Surgery
Fellowship Trained in Spinal Surgery

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Right sided L4-L5 transforaminal ESI - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
Evaluations with M.D. dated 04/12/02 and 06/19/02
Evaluation with M.D. dated 02/13/03
Evaluations
Lumbar MRI dated 06/27/12
Requests for epidural steroid injections (ESIs) 07/13/12, 07/17/12, and 08/06/12
Preauthorization notices from Prium dated 07/24/12 and 08/08/12
Utilization review notices from Liberty Mutual dated 07/25/12, 08/07/12, and 08/09/12

Letter from at Liberty Mutual addressed to Professional Associates dated 08/22/12
The carrier and/or the URA did not provide the Official Disability Guidelines (ODG) criteria used

PATIENT CLINICAL HISTORY [SUMMARY]:
On 01/31/12, Dr. noted the patient did not have any radiculopathy and Biolase, Mobic, and Vicodin were prescribed. Dr. examined the patient on 02/13/03. She had neck pain that radiated to her right shoulder and it was noted she was status post ACDF at C4-C5 and C5-C6 on 06/05/01. Robaxin, Trazodone, and Ultracet were prescribed. X-rays showed the fusion to be stable and intact. Dr. examined the patient on 12/16/04. She noted neck pain and difficulty swallowing. Dr. felt the patient was developing transitional syndrome below her fusion and a CT scan was ordered. The patient returned to Dr. on 04/02/12 and she complained of low back pain bilaterally down both legs posterolaterally. Lortab, Cyclobenzaprine, and Ambien were her medications. Talacen, Lodine, and physical therapy were prescribed. X-rays showed no instability in the lumbar spine and some narrowing at L4-L5 and L5-S1 with some degenerative scoliosis. Dr. noted on 06/05/12 that her therapy had been denied. She noted she had received 10 injections in the past. Dr. recommended a new MRI. A lumbar MRI was obtained on 06/27/12 and revealed moderate canal stenosis at L4-L5 related to a 7 to 8 mm. broad based posterior disc protrusion, degenerative facet joint changes, and hypertrophy. There was mild central canal stenosis at L5-S1 related to a 9 mm. broad based posterior protrusion and degenerative facet changes. There was borderline canal stenosis at L2-L3 with a 5 to 6 mm. diffuse bulge and at L3-L4 with a 4 to 5 mm. diffuse bulge with degenerative facet joint changes. At L1-L2, there was a 4 mm. annular diffuse bulge. Dr. reviewed the MRI on 07/13/12. He recommended a transforaminal L4-L5 ESI on the right. Liberty Mutual provided adverse determinations for the requested ESI on 07/25/12, 08/07/12, and 08/09/12.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
There are several reasons that the requested ESI is not appropriate. There is no evidence that the patient had a substantive change to her body at the time of the lumbar strain. The findings on the current diagnostic studies are consistent with degenerative disease. Further, there are no objective findings on the physical examinations. There is no objective evidence of radiculopathy. There is diffuse weakness in both lower extremities, unrelated to radiculopathy. The diffuse numbness in the right lower extremity is also poor evidence of radiculopathy. Straight leg raising sign is not expected with the diffuse spinal stenosis. Dr. has not presented objective evidence of radiculopathy to justify the request for an ESI, as required by the ODG. Therefore, the requested right sided transforaminal L4-L5 ESI is not reasonable or necessary and the previous adverse determinations should be upheld at this time.

DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- X **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**